# LONG TERM CARE SERVICES DIVISION

# STRATEGIC PLAN

# FISCAL YEAR 2004-05

CALIFORNIA DEPARTMENT OF

Mental Health


**Stephen W. Mayberg, Ph.D.**
**Director**

**Robert L. Garcia**
**Chief Deputy Director**

**John Rodriguez**
**Deputy Director**

**Cindy Radavsky**
**Assistant Deputy Director**

# *TABLE OF CONTENTS*



## *KEY PROCESSES*



September 2004

## *MISSION*

The Department of Mental Health, Long Term Care Services (LTCS), is entrusted with the administration and leadership of the California State Hospital System, the Forensic Conditional Release Program (CONREP), and treatment and evaluation of judicially, civilly committed and voluntary patients. The Division of Long Term Care Services provides additional consultation and evaluation services to state and county agencies. LTCS promotes hope and recovery for people with psychiatric disabilities, evidenced-based treatment based on accurate, complete and timely assessments, and collaboration with our patients to identify the individualized skills necessary to live effectively and successfully in the community. We strive to provide services that are responsive to the needs of our patients, cost effective, consistent with the needs of public safety, and have positive outcomes.

## *VISION*

Long Term Care Services envisions a time when:

- patients, staff, volunteers, family members, community mental health, courts, and CONREP work together to achieve a common goal of successful re-integration of patients into their communities;
- security and treatment are integrated to ensure a supportive therapeutic environment in a safe and secure setting;
- conflict is resolved in an atmosphere of mutual respect and dignity;
- state-of-the-art, evidenced based, culturally competent mental health care is the standard for all levels of our system;
- continuous improvement processes are fostered by leadership and supported by information management systems;
- staff, patients, and stakeholders participate in the performance improvement process;
- success is measured by outcomes;
- research and education lead to improved understanding of mental disorders, treatment strategies, and outcomes of care, and contributes to diminishing stigma and discrimination directed toward the mentally ill.

## *CORE VALUES*

***Leadership:***
The Long Term Care Services Division is committed to achieving and maintaining the role as a recognized state and national leader on issues affecting mental illness.

***Innovation:***
We value fostering an environment where innovative clinical and administrative approaches to treating patients, protecting staff and patients, and collaborating with external customers is encouraged in order to develop evidenced-based state-of-the-art treatments.

***Excellence:***
We value pursuit of clinical, forensic, and organizational excellence.

***Safety and Security:***
We value services that are provided in an emotionally and physically safe, compassionate, trusting and caring treatment/working environment for all patients, family members, staff and the community. We want to achieve and maintain a violence-free and coercion-free environment that is free of hurt, injury or danger.

***Dignity and Respect:***
We value an environment in which services are provided with respect for the rights and dignity of all individuals.

***Spirit of Community:***
We value a strong spirit of community by emphasizing employee creativity, open communication, and teamwork among staff, patients and families, all within the spirit of collaboration and pride of ownership.

***Individual Responsibility:***
We value individual responsibility and accountability. Employees and patients are encouraged to identify problems, propose solutions, and implement solutions.

***Partnerships:***
We value mutually beneficial collaborations with and between internal and external stakeholders. The Division of Long Term Care Services will be a partner with patients, family members, service providers and policy-makers in creating options responsive to the needs of the patients.

***Valuing Diversity*:**
We value and are committed to the patient-driven delivery of services that recognizes the importance of culturally sensitive support and competence.

***Equal Opportunity:***
We value and are committed to an environment of Equal Opportunity and non-discrimination. We value access to quality care which does not vary because of patient and family characteristics such as: race, ethnicity, age, gender, religion, sexual orientation, disability, diagnosis, geographic location, socioeconomic status or legal status.

***Recovery:***
We value the recovery philosophy of mental health care, which includes person-centered, strength-based, holistic, and recovery-focused assessment, planning, and treatment.

***Timely:***
We value goal-directed services that are promptly provided in order to restore and sustain the patients' and families' integration into the community.

***Efficient:***
We value use of human and physical resources in ways that minimize waste and optimize access to appropriate treatment.

***Hope:***
We value the belief that a patient has the ability to get better.

# ***ETHICS, RIGHTS & RESPONSIBILITIES (RI)***

## *GOAL*

Improve the care, treatment, services and outcomes by recognizing and respecting the rights of each patient and by conducting business in an ethical manner. Care, treatment, and services will be provided in a way that respects and fosters dignity, autonomy, positive self-regard, civil rights, and involvement of patients. Involve the patient's family in their care, treatment and service decisions with the patient's approval.

In consultation with internal and external partners, establish patients' rights which insure that these rights are protected except as necessary to ensure the safety and security of the facility, patients, staff, and public; provide effective treatment in the most appropriate environment.

## *OBJECTIVES*

1. By November 1, 2004, complete the development and implementation of the 880 Patients' Rights Handbook, the Denial of Rights (DOR) Form and revision to the hospitals administrative directive.

   **Responsible: Harry Booth and Executive Directors**

2. By January 1, 2005, all patients 21 years of age and under will have up-to-date Therapeutic Behavioral Services (TBS) evaluations.

   **Responsible: Mike Tucker and Executive Directors**

3. By February 1, 2005, revise the existing state hospital data collection and reporting process for Denial of Rights (DOR) utilizing, to the extent feasible, the data reporting elements developed by the statewide DOR data collection taskforce.

   **Responsible: Melody Martinez, Glenna Wheeler and Executive Directors**

# ***PROVISION OF CARE, TREATMENT & SERVICES (PC)***

## *GOAL*

Improve patient treatment outcomes by efficiently and effectively providing services that promote a recovery model of mental health care that is based on the assessed needs of the individual patient, the reduction of psychiatric symptoms and the increase of adaptive living skills. Complete person-centered and strength-based evaluations of patients to guide treatment and provide recovery focused assessments and reports to post-hospital care providers, for civil commitment recommendations to the Courts, and to the Board of Prison Terms. Facilitate coordination of uninterrupted patient treatment from pre-admission to post-discharge.

## *OBJECTIVES*

1. By January 31, 2005, formalize and initiate a project at Napa State Hospital to create a violence-free, coercion-free environment leading to the reduction of seclusion and restraints, and share successful elements with other DMH state hospitals.

   Elements to be included in the project shall be:

   - Adoption and implementation of a Recovery philosophy of treatment and service provision;
   - Education and training for staff and patients served in the model;
   - Development and implementation of Psychiatric Advanced Directives (PADs);
   - Develop and initiate meaningful Individual Safety Plans and debriefings;
   - Expanding the roles of patients served in mentoring, mediation, training and peer-support programs;
   - Assure the consideration of an assessment of trauma in the planning and delivery of care; and
   - Initiate a witnessing program that scrutinizes every instance of seclusion and restraint

   **Responsible: Cindy Radavsky and Dave Graziani**

2. By October 1, 2004, establish CONREP revised admissions criteria in policy.

   **Responsible: Jane Woehl and Chief, Forensic Services**

3. By June 30, 2005, CONREP providers will participate in the Master Treatment Plan (MTP) conference at all other state hospitals for PC 1026 and PC 2972 re-hospitalizations.

   **Responsible: Jane Woehl, and Chief, Forensic Services**

4. By October 1, 2004, CONREP providers will participate at Napa State Hospital's (NSH) first quarterly treatment planning conference for PC 1026 admissions.

   **Responsible: Jane Woehl, Chief, Forensic Services and Dave Graziani**

5. By June 30, 2005, CONREP providers will participate in the first quarterly treatment conference for PC 1026 admissions at all other state hospitals.

   **Responsible: Jane Woehl, Chief, Forensic Services and Executive Directors**

6. By October 31, 2004, each state hospital will have incorporated patients on at least three different hospital committees.

   **Responsible: Executive Directors**

7. By December 31, 2004, each state hospital will provide an orientation to patients on the hospital's enhancement plan.

   **Responsible: Executive Directors**

8. By April 30, 2005, each state hospital will provide an orientation to interested family members on the hospital's enhancement plan.

   **Responsible: Executive Directors**

# ***MEDICATION MANAGEMENT (MM)***

***GOAL***

Improve patient treatment outcomes by effectively and efficiently offering medication and other treatments based on scientific and biologically based assessments, evaluation and evidence-based treatment.

***OBJECTIVES***

1. By November 30, 2004, each state hospital and psychiatric program will update their plan to improve the quality, appropriateness and efficiency of psychopharmacology. The plan shall be updated annually and submitted to the Deputy Director of Long Term Care Services, and the Department's Medical Director.

   **Responsible: Executive Directors and Medical Directors**

2. By October 1, 2004, each state hospital and psychiatric program shall have in place a plan for a pilot program and hospital-wide implementation of an adaptation of the California Medical Algorithm Program (Cal MAP) for the treatment of psychosis.

   Each plan should address staff training and education, as well as changes in medical records, pharmacy operations, IT support and other hospital operations required for implementation. A mechanism for monitoring the implementation of the algorithm by practitioners should be included. The plans should be reviewed and approved for fidelity by the DMH Medical Director and the Medical Directors' Council.

   **Responsible: Medical Directors and Neal Adams**

3. By November 1, 2005, each state hospital and psychiatric program shall complete the evaluation of the Cal MAP pilot project and have in place a plan for full hospital implementation.

   **Responsible: Medical Directors and Neal Adams**

4. By March 1, 2005, the Medical Directors' Council, in collaboration with the Psychopharmacology Advisory Committee will develop and implement protocols or guidelines for the evaluation and management of obesity, diabetes, hypertension and other metabolic consequences of psychopharamacotherapy.

   **Responsible: Medical Directors and Neal Adams**

5. By March 1, 2005, each state hospital will adopt guidelines or algorithms for the management of at least three of the medical conditions list below, and will have a

mechanism in place for the regular and periodic monitoring of adherence to these guidelines by hospital physicians and nurse practitioners. The psychiatric programs will adopt guidelines or algorithms for the management of chronic pain.

- Chronic pulmonary disorders (e.g., asthma, COPD)
- Diabetes
- Hypertension
- Hepatitis C
- Allergic Rhinitis Dyslipedemia
- Congestive heart failure
- Chronic pain

**Responsible: Medical Directors and Neal Adams**

6. By (insert date), improve patient treatment objectives by efficiently and effectively offering medication and other treatments based on scientific and biologically based assessment, evaluation and evidence-based treatment.

   **Responsible: Medical Directors and Neal Adams**

# ***IMPROVING ORGANIZATIONAL PERFORMANCE (PI)***

***GOAL***

Maintain our role as recognized state and national leaders on issues affecting persons with mental illness while working towards a more effective mental health system that values recovery, hope and excellence.

***OBJECTIVES***

1. By March 30, 2005, each DMH state hospital and psychiatric program will provide cultural competence education and training in conjunction with the recovery philosophy training. Training records and facility training plans will measure this objective.

   **Responsible: Executive Directors and Rachel Guerrero**

2. By December 1, 2004, each state hospital will have a detailed enhancement plan, including milestones and due dates, which guides the transition to the Recovery Model of mental health treatment in the facility.

   **Responsible: Executive Directors**

# ***LEADERSHIP (LD)***

***GOAL***

Maintain our role as recognized state and national leaders on issues affecting persons with mental illness while working towards a more effective mental health system that values recovery, hope and excellence.

***OBJECTIVES***

1. By December 23, 2004, Coalinga State Hospital will take possession of the completed Administration, Warehouse, and Plant Operations Buildings.

   **Responsible: Tom Voss**

2. By August 9, 2005, Coalinga State Hospital will have completed the Department of Health Services' pre-opening licensure survey**.**

   **Responsible: Tom Voss**

3. By November 30, 2005, Coalinga State Hospital will complete implementation of all steps of the Hospital Activation Plan necessary to open the facility and receive patients.

   **Responsible: Tom Voss**

4. By October 1, 2004, Long Term Care Services will develop best practice procedures for the initial assessment process that includes issues specific to the use of seclusion and restraints.

   **Responsible: Cindy Radavsky, Melody Martinez, Harry Booth, Medical Directors, and Clinical Administrators**

5. By February 1, 2005, Long Term Care Services will develop draft procedures for the recognition and use of Psychiatric Advance Directives (PADs).

   **Responsible: Dave Graziani, Melody Martinez and Harry Booth**

6. By August 1, 2005, Napa State Hospital will complete a pilot of the use of patient preference guidelines and make recommendations for the final procedure to be implemented at each state hospital and psychiatric program.

   **Responsible: Dave Graziani and Harry Booth**

7. By October 1, 2005, each state hospital and psychiatric program will develop a plan to implement the patient preference guidelines. The plan will include training, revision of policies and procedures and timeframes. The plan shall be submitted to the LTCS Deputy Director.

   **Responsible: Executive Directors**

# ***MANAGEMENT OF THE ENVIRONMENT OF CARE (EC)***

***GOAL***

LTCS Management will plan for and provide appropriate housing, treatment space, and replacement of infrastructure to provide a safe, secure, accessible and energy efficient environment for all patients, staff, and visitors.

***OBJECTIVES***

1. By December 30, 2004, the Department of Mental Health with have a plan authorized by the Department of Health Services (DHS) for managing over-bedding in the state hospitals until space is available at Coalinga State Hospital (CSH).

   **Responsible: Executive Directors' Council and Mike Tucker**

# ***MANAGEMENT OF HUMAN RESOURCES (HR)***

***GOAL***

Provide qualified, professional, and competent staff in an environment that respects, involves, provides appropriate training and creates opportunities for all employees.

***OBJECTIVES***

1. To meet the requirements of the Division of LTCS organizational cultural competency self-assessment each DMH state hospital and psychiatric program will provide a status report on their organizational cultural competency self-assessment, and provide the findings to the LTCS Deputy Director in the form of a written report that includes organizational strengths and weaknesses as they relate to the provision of services to ethnic, and racial minorities.

   a. By October 31, 2004 a status report from each DMH state hospital or psychiatric program on organizational cultural competency self-assessment due to LTCS Deputy Director.

   b. By February 28, 2005 a status report from each DMH state hospital or psychiatric program on organizational cultural competency self-assessment due to LTCS Deputy Director.

   c. By May 31, 2005 a status report from each DMH state hospital or psychiatric program on organizational cultural competency self-assessment due to LTCS Deputy Director.

   **Responsible: Executive Directors and Rachel Guerrero**

2. By September 1, 2005, each DMH state hospital will review their strategic plan to incorporate the Long Term Care Services (LTCS) Cultural Competence Plan adopted in 2002 into the implementation of their recovery enhancement efforts.

   **Responsible: Executive Directors and Rachel Guerrero**

# ***MANAGEMENT OF INFORMATION (IM)***

***GOAL***

Obtain, manage, and use information to improve the performance of the LTCS Division, its program, hospitals, and staff in patient care and support services.

***OBJECTIVES***

1. By October 29, 2004, LTCS will develop a plan to make maximum use of video-conferencing resources for patient court appearances.

   **Responsible: Executive Directors and Forensic Coordinators**

2. By December 31, 2004, construct a complete list of identified patients who have passed away while residing in the state hospital system (in support of the California Memorial Project).

   **Responsible: Executive Directors, Harry Booth and Dave Gerard**

3. By December 31, 2004, identify former patients whose bodies were donated for research (in support of the California Memorial Project).

   **Responsible: Executive Directors, Harry Booth and Dave Gerard**

4. By December 31, 2004, DMH will have identified the approximate location of cemeteries of patients who passed away while residing at a state hospital or while living on state-owned lands**.**

   **Responsible: Executive Directors and Cemetery Project Task Force**

5. By October 1, 2004, develop a process to publish emergency medication and serious injury date (related to seclusion & restraint) on DMH website/Internet.

   **Responsible: Melody Martinez, Harry Booth and Headquarters IT Staff**

6. By January 1, 2005, develop a process to publish psychiatric program seclusion, restraint, injury and emergency medication data on DMH website/internet.

   **Responsible: Melody Martinez, Harry Booth and Headquarters IT Staff**

7. By December 31, 2004, an automated treatment scheduling system that is consistent with the recovery model of mental health, to be called the Wellness and Recovery Model Support System (WARMSS), will be developed for testing. The system will include uniform core features as well as locally desired options suited to individual hospital needs and tradition.

   **Responsible: Executive Directors and Michael O'Connor**

8. By June 30, 2005, an automated treatment scheduling system that is consistent with the recovery model of mental health, to be called the Wellness and Recovery Model Support System (WARMSS), will be tested and deployed at all state hospitals.

   **Responsible: Executive Directors and Michael O'Connor**

9. By September 1, 2004, and annually thereafter, a report evaluating state hospital services will be submitted to the Deputy Director of Long Term Care Services (LTCS) for approval and distribution. The report will provide statistical and text analysis of available data concerning clinical effectiveness, patient and staff safety, consumer satisfaction with services, cost, and other issues identified by management. The report will compare California state hospital performances to available comparisons, including but not limited to the national averages of the Performance Measurements System (PMS) maintained by the National Association of State Mental Health Program Directors (NASMHPD). Each report will also compare current-year data with prior-year benchmarks.

   **Responsible: Mark Wiederanders**

10. By December 30, 2004, and annually thereafter each state hospital and psychiatric program will complete the Joint Commission of Accreditation of Hospital Operations (JCAHO) Self-Assessment process.

    **Responsible: Executive Directors**

11. By April 20, 2005, DMH will implement reasonable and appropriate policies and procedures to comply with the requirements of the Final Security Rule of the Health Insurance Portability and Accountability Act (HIPAA) in order to physically, technically, and administratively safeguard all electronic protected health information.

    **Responsible: Executive Directors and Mike Tucker**

# ***SURVEILLANCE, PREVENTION & CONTROL OF INFECTION (IC)***

## *GOAL*

Decrease the potential for the spread of, at a minimum, Hepatitis B and Varicella in DMH facilities. (Other vaccine-preventable diseases may be added depending on clinical/epidemiologic data and the availability of resources.)

## *OBJECTIVES*

1. By September 1, 2005, each state hospital and psychiatric program will develop an Administrative Directive to assure that within 30 days of admission and then annually, 90% of patients will be screened for risk of infection and education will be provided to that risk.

   **Responsible: Medical Directors and Neal Adams**

2. By September 1, 2005, each state hospital and psychiatric program will develop an Administrative Directive to assure that within 90 days of admission, and at clinically appropriate intervals thereafter, 90% of at risk individuals will be provided testing for immunologic status and potential need for vaccination.

   **Responsible: Medical Directors and Neal Adams**

3. By September 1, 2005, each state hospital and psychiatric program will develop an Administrative Directive to assure that within 90 days of identifying a patient's non-immune status, vaccination will be offered and provided as clinically appropriate to 100% of eligible patients.

   **Responsible: Medical Directors and Neal Adams**

# *SECURITY*

## *GOAL*

Acquire, manage and provide information necessary to measure, monitor, and improve performance regarding internal and perimeter security practices for the purpose of providing a safe and secure treatment environment for patients, and staff, and to protect the surrounding community at each state hospital location.

## *OBJECTIVES*

1. By October 29, 2004, and annually thereafter, security audits of all state hospitals will be completed.

   **Responsible: Chief Hospital Security and Safety**

2. Within 30 days of the annual security audit, any state hospital who has not received a full 100% compliant rating on their security review will submit a plan of correction to the Deputy Director of Long Term Care Services to address audit deficiencies.

   **Responsible: Executive Directors, Chief Hospital Security and Safety**

# ***MANAGEMENT OF FISCAL RESOURCES (FR)***

***GOAL***

Provide continuous improvement of fiscal systems, processes and reporting requirements.

***OBJECTIVES***

1. By January 1, 2005, each state hospital will reduce its Medicare error rate for all reported categories, as measured by its 100 percent internal audit, to less than 5 percent.

   **Responsible: Mike Tucker and Executive Directors**

2. By January 1, 2005, each state hospital will reduce its Medicare error rate as measured by the Department of Developmental Services (DDS) Medicare Compliance Performance Audit, to less than 5 percent.

   **Responsible: Mike Tucker and Executive Directors**

3. By March 31, 2005, each state hospital will reduce obvious cost accounting errors, as reflected on the State Hospital Comparison analysis, to no more than two.

   **Responsible: Mike Tucker and Executive Directors**

4. By April 1, 2005, where the Medicare error rate exceeds 5 percent, the state hospital will specify corrective action taken to achieve an error rate of no more than 3 percent.

   **Responsible: Mike Tucker and Executive Directors**

5. By June 30, 2005, each state hospital will reduce its Medicare error rate for all categories, as measured by its 100 percent internal audit to less than 3 percent.

   **Responsible: Mike Tucker and Executive Directors**

6. By June 30, 2005, each state hospital will reduce its Medicare error rate as measured by the DDS Medicare Compliance Performance Audit to less than 3 percent.

   **Responsible: Mike Tucker and Executive Directors**

7. By June 30, 2005, each state hospital will reduce discretionary expenses to remain within the budget allocations it has been given for the entire year.

   **Responsible: Mike Tucker and Executive Directors**

8. By June 30, 2006, eliminate all obvious cost accounting errors, as reflected on the State Hospital Comparison analysis. Obvious errors include acute program costs less than sub acute program costs, ancillary costs and few or no units, ancillary services unit costs much higher than normal and significant costs shifting without explanation.

   **Responsible: Mike Tucker and Executive Directors**